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Update: In February 2008, the Internal Revenue Service issued Notice 2008–23, which is similar to the Department of Labor's Field Assistance Bulletin discussed in this *Bulletin*. (The Department of Health and Human Services has also issued guidance on supplemental benefits.)

January 2008

New Guidance Affecting Health Plans Offering Wellness Programs

The Department of Labor (DOL) recently released a new Field Assistance Bulletin (FAB No. 2007-04)[1] that has important implications for health plan sponsors offering wellness programs. The FAB sets out specific requirements that must be met in order for benefits to qualify as supplemental excepted benefits under the Health Insurance Portability and Accountability Act (HIPAA) and, thus, to be exempt from HIPAA portability, nondiscrimination/wellness, and special enrollment requirements. The FAB was published in response to insured wellness programs that claimed to be supplemental excepted benefits under HIPAA and, therefore, not subject to the HIPAA nondiscrimination/wellness program rules.[2]

Although issued by the Department of Labor, the FAB was developed on a coordinated basis with the Departments of Treasury and Health and Human Services (HHS), and will affect plans governed by ERISA, as well as those that are not. The FAB indicates that Treasury and HHS will issue additional guidance.

BACKGROUND

The HIPAA wellness rules generally prohibit rewards or penalties that are based on health status, unless the plan complies with certain specific requirements.[3] Certain types of "excepted benefits" are exempt from compliance with the HIPAA wellness rules (along with other HIPAA requirements). One type of "excepted benefits" is "supplemental" coverage that is similar to Medicare supplemental health insurance (Medigap) and TRICARE supplemental insurance.

The final HIPAA portability regulations published in 2004 discuss the requirements that apply to supplemental excepted benefits.[4] Under those regulations, such coverage must be:

- Provided under a separate policy, certificate, or contract of insurance, and
- Specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles.

THE FAB NO. 2007-04 SAFE HARBOR

The FAB establishes an enforcement safe harbor under which supplemental health insurance will be treated as excepted benefits. The FAB states that similar coverage that does not meet the standards set out in the FAB may be subject to enforcement actions by DOL.

To fall within the safe harbor, the separate policy/certificate/contract of insurance must meet the following four requirements:

- It must be issued by an entity that does not provide the primary coverage under the plan. For this purpose, entities that are part of the same controlled group or part of the same group of trades or businesses under common control are treated as a single entity.

[1] The FAB, which was released on December 7, 2007, is available at http://www.dol.gov/ebsa/pdf/fab2007-4.pdf

[2] The final nondiscrimination and wellness rules (71 Fed. Reg. 75014 (December 13, 2006)) are available at http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/pdf/06-9557.pdf The rules are effective for plan years beginning on or after July 1, 2007 (January 1, 2008, for calendar year plans).

[3] Among the key requirements under the wellness program rules are the requirements that (1) the reward not exceed 20 percent of the cost of the coverage; (2) the plan provide a reasonable alternative for people who for medical reasons cannot meet the health objectives or even attempt to do so; and (3) the existence of the alternative be disclosed in all program materials. A January 2007 Segal *Bulletin* discussing the wellness program rules is available on the following Web page: http://www.segalco.com/publications/bulletins/jan07HIPAA.pdf

[4] 69 Fed. Reg. 78720, 78762, 78780 & 78799 (December 30, 2004), available at http://a257.g.akamaitech.net/7/257/2422/06jun20041800/edocket.access.gpo.gov/2004/pdf/04-28112.pdf

- It must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles, but does not include a policy that becomes secondary or supplemental only as result of coordination of benefits (COB).

- The cost of the supplemental coverage must not exceed 15 percent of the cost of primary coverage (with cost determined in the same manner as for COBRA premiums).

- It must not differentiate among individuals in eligibility, benefits, or premiums based on any health factor of the individual (or any dependent of the individual). (This requirement stems from comparable nondiscrimination provisions applicable to Medicare supplemental plans.)

IMPACT ON WELLNESS PROGRAMS

Some group health plans offer an insured deductible-reimbursement program that reimburses individuals based on whether they meet a health status measure. For example, an insured product might give plan participants credits worth $500 each for the following measurements: blood pressure, body mass index (BMI), cholesterol and non-tobacco use. Consequently, if the plan had a $2,500 deductible, and the employee met all four health standards, their deductible would be only $500.

Under the new FAB rule, programs like that described above would fail the supplemental benefit test because only people who actually meet certain health objectives can lower their deductible. Consequently, plans that reimburse deductibles or provide other benefits based on certain health objectives cannot avoid the HIPAA wellness rules merely by claiming they are an insured supplemental plan.

NEXT STEPS FOR PLAN SPONSORS

Plan sponsors that provide a wellness program through an insurer should investigate whether the program it offers is subject to HIPAA's nondiscrimination/wellness program rules – both under the final rules effective January 1, 2008 (for calendar year plans) and the new FAB. Insurers offering a program that does not appear to fit the guidelines should be asked to either remove the program or modify it to comply with HIPAA. This may require a design change in the program, most likely relating to the amount of the reward and/or the addition of a reasonable alternative to achieving the desired health objective.

When implementing a wellness program a plan sponsor should consider two important factors: (1) is the wellness program focused on specific needs (*e.g.*, diabetes, asthma, heart disease) of the participant population, and (2) have all barriers within the core medical plan that discourage participants from getting needed care for their chronic condition been removed? For example, if the wellness program is designed to encourage the participants to get regular preventive care, preventive care limits or exclusions in the medical plan will work counter to the wellness goals. Off-the-shelf deductible reimbursement programs or other insured programs may not focus on the real needs of plan participants, so plan sponsors should first identify the health-risk factors that are driving costs within their participant population. Once that is known, the wellness program can be developed.

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As with all issues involving the interpretation or application of laws and regulations, plan sponsors should rely on their attorneys for authoritative advice on the interpretation and application of this FAB. Segal can be retained to work with plan sponsors and their attorneys to assess the impact of the guidance and design appropriate wellness programs.

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Benefits, Compensation and HR Consulting

October 2007

Final Regulations for Section 403(b) Plans

The Internal Revenue Service (IRS) and Treasury Department have issued much anticipated final regulations on tax-sheltered annuity plans under IRC §403(b).[1] These regulations provide the first comprehensive guidance for §403(b) plans in more than 40 years. Like the proposed rules,[2] the final regulations consolidate a number of statutory changes and IRS rulings or guidance into a single source. The final regulations, which will require changes to virtually all §403(b) plans, are generally effective for taxable years beginning or after January 1, 2009, with some transition rules for certain provisions.

KEY PROVISIONS

This section summarizes the key provisions of the final regulations for governmental employers that were changed from the proposed final regulations.[3]

Written Plan Requirements

The final regulations retain the requirement from the proposed rules that §403(b) plans be maintained under a written plan that describes all material terms of the arrangement. The written instrument need not be a single document and can incorporate other documents by reference. However, the final regulations indicate that for a plan funded through multiple providers, the IRS expects a single plan document, rather than a separate document for each provider. The written plan requirements are designed to ensure that the roles and responsibilities of the plan are properly allocated to specific parties, eligibility rules that satisfy universal availability requirements are delineated and there are no contradictory terms in the plan. The IRS will soon publish a model plan document for public school employers.

The regulations indicate that plans with multiple providers can continue to allocate the administration of compliance requirements to those providers. However, the plan must provide rules for coordinating loan eligibility and limitations and hardship eligibility across providers and for determining whether a severance of employment has occurred before benefits are distributed. The regulations clearly indicate that it is inappropriate to allocate responsibility for these compliance requirements to employees.

Contract Exchanges and Transfers

The final regulations make significant changes in the rules governing changes in investment vehicles both within a plan ("exchanges") and between plans ("transfers"). Nontaxable exchanges and/or transfers are only permitted if: (1) the plan(s) specifically permit the exchange/transfer; (2) the recipient vehicle's distribution rules are at least as stringent as those of the transferring vehicle; and (3) the benefit payable immediately following the exchange/transfer is equal to the benefit prior to the exchange/transfer. In addition, for exchanges within a plan, the employer must enter into an information-sharing agreement with providers whereby both parties agree to provide information on an on-going basis necessary to satisfy tax requirements, such as the participant's employment status, hardship withdrawals and plan loans. These new rules apply to exchanges made after September 24, 2007.

Timing of Contributions

The final regulations retain the proposed rule requiring contributions to the plan be transmitted to the funding vehicles within a reasonable period after being withheld from participants' pay. The example in the regulations follows the rule that elective deferrals be remitted to the plan within 15 business days following the month in which these amounts would have otherwise been paid to the participant.

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[1] The final regulations were published in the *Federal Register*: http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-3649.pdf

[2] The Segal Company's *Compliance Alert* on the proposed regulations is available on the following Web page: http://www.segalco.com/publications/compliancealert/010405.html

[3] Because the final regulations follow the proposed regulations with respect to catch-up contributions, vesting and plan termination, please refer to the *Compliance Alert* referenced in footnote 2 for those provisions.

Withdrawal Restrictions

The regulations add new restrictions on withdrawals of employer contributions, permitting distribution only upon severance of employment or occurrence of certain events, such as disability, attainment of a particular age or a fixed number of years. Previously, there were no restrictions on withdrawal of employer contributions. In addition, the final regulations clarify that after-tax employee contributions are not subject to withdrawal restrictions.

Life Insurance

The regulations specifically prohibit life insurance or other incidental benefits within a §403(b) contract that is issued after September 23, 2007. Contracts with life insurance issued before such date are grandfathered.

Universal Availability

The regulations make some important clarifications to the universal availability test, which requires the ability to make elective deferrals (including designated Roth contributions, if permitted by the plan) to a §403(b) plan be "universally available" to all employees not specifically excluded, as follows:

- The universal availability requirement applies separately to each entity not part of a common payroll;
- The exclusion of employees who normally work less than 20 hours per week is not applicable if the employee is expected to work more than 1,000 hours in a year or worked more than 1,000 hours in the previous year;
- An employee must be given an "effective opportunity" to make elective deferrals, by receiving a notice of the availability to make (or change) an election each year; and
- Employees of a governmental plan who can make a one-time election to participate in a plan that does not permit elective deferrals (such as a §401(a) optional retirement plan), instead of a §403(b) plan, are no longer an excludible class under universal availability rules due to the repeal of IRS Notice 89-23, effective January 1, 2010.

These final rules come on the heels of an IRS announcement in June that they are expanding an outreach effort to ensure public schools comply with the "universal availability" requirements.[4]

[4] This IRS announcement can be found at http://www.irs.gov/retirement/article/0,,id=171019,00.html

IMPLICATIONS FOR EMPLOYERS

Under the final regulations, it appears that employers offering a §403(b) plan should, at a minimum, take the following steps:

- Create and maintain a written plan that satisfies the requirements under the regulations. This likely means gathering data regarding employee eligibility, optional provisions offered under the plan (such as loans and hardships) and information on all authorized providers and products.
- Review plan operations and work with the providers to ensure all tax compliance requirements are satisfied, including coordinating the responsibilities of employer and providers.
- Enter into information-sharing agreements with all authorized providers within the plan in order to facilitate contract exchanges.
- Review, and if necessary amend, administrative rules regarding who is eligible to participate in the §403(b) plan and election forms/notices to ensure compliance with universal availability rules.

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As with all issues involving the interpretation or application of laws, employers should rely on their legal counsel for authoritative advice on the final §403(b) regulations. The Segal Company can be retained to work with employers and their attorneys to comply with the regulations.

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Bulletin

Benefits, Compensation and HR Consulting

August 2007

GASB Issues New Pension Disclosure Rules

The Governmental Accounting Standards Board (GASB) has issued Statement No. 50, *Pension Disclosures*,[1] which amends GASB Statements No. 25, *Financial Reporting for Defined Benefit Pension Plans and Note Disclosures for Defined Contribution Plans*, and No. 27, *Accounting for Pensions by State and Local Governmental Employers*.[2] The amendments align the financial reporting requirements for pensions with the reporting requirements for other postemployment benefits (OPEB) under Statements No. 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, and No. 45, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions*.[3] GASB's goal is to improve the transparency of financial reporting by public sector employers and retirement plans. The changes affect public sector retirement plans and the employers that sponsor them.

This *Bulletin* summarizes the changes introduced by Statement No. 50, which follows the Exposure Draft that GASB issued in late December 2006. The provisions of Statement 50 generally are effective for periods beginning after June 15, 2007.

THE CHANGES

GASB requires changes to notes to financial statements or required supplementary information (RSI). Plans and sponsoring employers are now required to disclose the following in notes to their financial statements:

- The funded status of the plan as of the most recent actuarial valuation date,
- Narrative about the actuarial measurement process,
- The initial and ultimate actuarial assumption rates, if they differ for successive years,
- Legal or contractual maximum contribution rates, if applicable, and, if relevant, disclosure that the maximum contribution rates have not been taken into consideration in the projection of pension benefits for financial accounting measurement purposes, and
- If the aggregate actuarial cost method is used to determine the annual required contribution of the employer (ARC), the funded status (as well as the schedule of funding progress presented in the RSI) would be presented using the entry age actuarial cost method. (Currently, governments that use the aggregate actuarial cost method do not disclose this information.) These requirements are effective for financial statements and required supplementary information that contains information from actuarial valuations as of June 15, 2007 or later.

The notes to financial statements also have to include a reference linking the funded status disclosure to the required schedule of funding progress in RSI.

In addition, plans (not sponsoring employers) have to disclose the following in notes to financial statements:

- Actuarial methods and significant assumptions used in the most recent actuarial valuation (currently reported in notes to RSI), and

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[1] Statement No. 50 can be purchased from GASB (www.gasb.org).

[2] The Segal Company discussed Statements No. 25 and 27 in a March 1995 *Bulletin*, "GASB's Final Reporting and Disclosure Rules for Governmental Pension Plans Change Accounting Practices Significantly": http://www.segalco.com/publications/bulletins/march95GASB.pdf

[3] For more information about Statements No. 43 and 45, see Segal's August 2004 *Bulletin*, "Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions: GASB's Final Standards": http://www.segalco.com/publications/bulletins/aug04GASB.pdf

- The methods and assumptions used to determine the fair value of investments, if the fair value is based on other than quoted market prices.

Cost-sharing employers have to include the following in the note disclosure of the required contribution rates:

- The required contribution in dollars and the percentage of that amount contributed for the current year and each of the two preceding years, and

- How the contractually required contribution rate is determined (*e.g.*, by statute or by contract, or on an actuarially determined basis) or that the cost-sharing plan is financed on a pay-as-you-go basis.

An employer in a cost-sharing plan that does not issue a publicly available stand-alone plan financial report prepared in accordance with the requirements of Statement 25, as amended, must present as RSI the schedules of funding progress and employer contributions for the plan (and notes to these schedules) unless the plan is included in the financial report of another entity.

TRANSITION PERIOD

In the initial year of implementation, defined benefit pension plans and sole and agent employers that use the aggregate actuarial cost method to determine the ARC are required to present elements of information in the schedule of funding progress using the entry age actuarial cost method as of the most recent actuarial valuation date. In subsequent years, that schedule will include information from future actuarial valuations until the minimum number of years required under Statements 25 and 27, as amended, have been met.

IMPLICATIONS

By requiring that pension information formerly presented in RSI now appear in notes, GASB has increased the visibility of that information. This is likely to lead to heightened scrutiny of pension reporting from participants, taxpayers, governing bodies and rating agencies.

There is some question whether moving pension disclosures from RSI to notes will require auditors to increase their level of review of the pension information being disclosed (*i.e.*, attest to actuarially determined information). Such a procedural change would result in higher costs for the plans.

ADDITIONAL GUIDANCE POSSIBLE

GASB is conducting a research project to determine the effectiveness of existing accounting standards for governmental plans. Consequently, additional guidance is possible.

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Segal can be retained to work with employers, plan sponsors and their auditors in their efforts to determine the impact of the requirements in GASB Statement No. 50 on their plans and practices.

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SEGAL Public Sector Letter

Benefits, Compensation and HR Consulting NOVEMBER 2007

In Search of OPEB Remedies: Good Medicine Includes Managing Retiree Health Care Costs

Many public sector employers have assessed future retiree health care liabilities and are now seeking financial and fiscal strategies to manage both the benefits and their related costs. The Governmental Accounting Standards Board (GASB), under Statements No. 43 and No. 45, requires large employers to disclose liabilities for non-pension retirement benefits — often referred to as "other postemployment benefits" (OPEB) — starting this fiscal year, with smaller jurisdictions' compliance phased in through fiscal years beginning in 2009.[1]

"As employers comply with GASB disclosure, they are more keenly aware of the need to understand and manage the costs of OPEB."

As employers comply with GASB disclosure, they are more keenly aware of the need to understand and manage the costs of OPEB. Although the OPEB reporting requirement covers all non-pension benefits provided to retirees, such as dental, vision or legal services, this *Public Sector Letter* focuses on health care because it is the highest cost component of OPEB reporting. It also presents an overview of options or mitigating OPEB liabilities, including retiree health care prefunding vehicles and plan design changes.

[1] The Segal Company's August 2007 *Public Sector Letter* focused on the significance of the new OPEB reporting requirement. That issue is available on the following Web page: http://www.segalco.com/publications/publicsectorletters/aug2007.pdf

Prefunding and Savings Vehicles

GASB generally requires that liabilities be disclosed — not funded. However, in order for accumulated plan assets to offset OPEB liabilities, all of the following requirements must be satisfied:

- Plan assets must be transferred to an irrevocable trust (or equivalent arrangement).
- Plan assets must be dedicated to providing benefits to retirees and their beneficiaries under the terms of the plan.
- Plan assets must be legally protected from creditors of the employer and plan administrator.

Because there are no specific rules regarding the structure of an OPEB plan, plan sponsors that decide to prefund OPEB can use any of the vehicles described briefly below:

- ***Section 115 Trust*** This trust fund excludes from gross income any investment or other income to a governmental entity that is derived from the exercise of an essential governmental function under Internal Revenue Code (IRC) §115. The Internal Revenue Service (IRS) has indicated in Private Letter Rulings (PLRs) that providing health care to retirees can be such a function. This is the most common and simplest type of trust for prefunding retiree benefits. However, a §115 trust must be specifically designed to be irrevocable under applicable state or local law requirements in order for its assets to offset OPEB liabilities.[2]

[2] Several states and other jurisdictions have legislation establishing a specific form of §115 trust. A supplement to this *Public Sector Letter* provides more information about these and other prefunding initiatives. That supplement is available on the following Web page: http://www.segalco.com/publications/publicsectorletters/nov07supp1.pdf

IN THIS ISSUE:

Plan sponsors seeking to establish a §115 trust should consider seeking a PLR to assure that the benefits can be provided tax-free.

- ***IRC §401(h) Account*** This is a separate account established within a defined benefit plan's trust fund for the sole purpose of providing retiree medical benefits. Contributions to the §401(h) account may not exceed 25 percent of the contributions made to the defined benefit retirement plan in any year. Thus, if the defined benefit plan is well-funded, contributions to the §401(h) account may be severely limited. However, other sources of funding are available. If the defined benefit plan is significantly overfunded, excess pension assets may be transferred to the §401(h) account under rules set forth in IRC §420. Also, these arrangements provide flexibility to permit employee contributions under certain circumstances.
- ***Voluntary Employees' Beneficiary Association (VEBA)*** A VEBA trust fund vehicle governed by IRC §501(c)(9) permits an employer to set aside funds for specific purposes only (*e.g.*, life, sickness, accident or other benefits) for its participants. IRS approval is required and the VEBA is subject to funding limitations but may be funded for OPEB liabilities. Retiree health benefits

paid from the VEBA are tax-free. Additional requirements for membership and governance of the trust under IRC §501(c)(9) apply. Governments adopting OPEB funding trusts to date have been more inclined to use the more familiar irrevocable §115 trust than a VEBA as a prefunding approach. VEBAs are likely to be given more consideration following recent collective bargaining agreements resulting in unions establishing these arrangements.

- ***Health Reimbursement Arrangement (HRA)*** This savings vehicle allows employers to set up individual accounts for employees. The HRA must be partnered with an irrevocable trust in order for its assets to indirectly offset OPEB liabilities. HRAs must be funded with employer contributions only (during active employment or retirement) and cannot be used for any purpose other than qualified medical expenses.

All of these prefunding and savings vehicles, can be designed so that the assets offset OPEB liabilities and allow tax-free payment of benefits for medical care under IRC §105. The merits and shortcomings of these approaches are compared in an online supplement to this *Public Sector Letter*.[3]

Sources of Funds

For plan sponsors that decide to prefund OPEB liabilities, it is important to consider how to maximize funding sources provided by both the employer and employees. Two options are described below:

- ***"OPEB Bonds"*** One source of funding is for the plan sponsor to issue taxable municipal bonds, invest the proceeds and create an irrevocable trust to pay future benefits. This approach assumes that the yield paid to the bondholders of these OPEB bonds would be lower than the return on the invested proceeds. The spread (known as arbitrage), along with the bond proceeds, would be used to pay future retiree health benefits. This strategy needs to be carefully assessed on several levels, including how much of the liability to bond, how it effects the overall borrowing and debt profile of the issuing entity, current investment options, restrictions and/or yields and future growth of health care liabilities, which could be more volatile than traditional defined benefit pension liabilities.

"For plan sponsors that decide to prefund OPEB liabilities, it is important to consider how to maximize funding sources."

- ***Employer and Employee Contributions*** Another option is to have employers and employees contribute a surcharge as part of the regular health insurance rates to create a stream of cash coming into the retiree health trust. For example, the monthly rates could include an additional 2 percent for both employee and employer contributions, which would then be used to help prefund the retiree health benefit liability. Alternatively, certain trusts can be funded through unused sick leave/vacation conversions.

Other than the §401(h) account, funding vehicles can generally accept employee contributions only on an after-tax basis. However, even in those funding vehicles it may be possible for employers to require employees to convert some portion of unused leave and/or contribute some portion of future pay increases into the trust fund on a pre-tax basis. By having the employee and the employer each contribute a small additional percentage of their pay (or costs) each pay period beyond that needed for current plan costs, the jurisdiction can help to build longer term funding of OPEB liabilities.

Maximizing Returns on Trust Assets

Some states place limits on the asset classes in which governmental entities can invest. Jurisdictions affected by such rules might want to explore crafting legislation that would enable prefunded retiree health trusts to invest more aggressively given the magnitude and the long-term nature of OPEB liabilities. Forming joint investment pool trusts might help.

For example, several jurisdictions are considering or have already implemented changes necessary to invest the separate retiree health trust fund on a commingled basis with the retirement system's assets. This arrangement takes advantage of economies of scale (by investing large amounts with a long-term investment horizon), utilizes the expertise of the retirement system's investment advisor, and reduces administrative costs.

Other jurisdictions (such as school districts) are forming coalitions for the same purpose. In these coalitions, the individual employer maintains separate accounting of trust assets, but pools those assets with other governmental employers for more efficient investment and administration of benefits.[4]

[3] This supplement, which is a summary table, is available on the following Web page: http://www.segalco.com/publications/publicsectorletters/nov07supp2.pdf

[4] Segal Advisors, The Segal Company's investment consulting affiliate, can provide assistance with investing plan assets. For more information about Segal Advisors, visit www.segaladvisors.com

Plan Design Changes

GASB Statements No. 43 and No. 45 are already triggering close scrutiny of existing retiree health benefit programs. The following are among the program design changes being considered by public employers, including some options that represent more extreme alterations:

- ***"Dynamic Redesign"*** This refers to a current agreement to make changes in the future. For example, deductibles, out-of-pocket maximums, copayments and/or retiree contributions can be indexed to some measure of inflation. In collectively bargained plans, agreement to make such future changes would have to be part of the bargaining agreement. The parties might agree that employees retiring after a certain date in the future would pay a larger share of the benefit cost for the existing plan, or continue to pay the same share of cost for a less rich specified plan design. The same type of prospective plan change could be accomplished even when there is no collective bargaining, by a memorandum of agreement and published specifications for the new plan to become effective on a certain date. Provided the change represents a believable commitment, the plan's actuary could take it into account now when estimating OPEB liabilities.
- ***Reduce Current Coverage through Plan Redesign*** Immediate reductions can also be accomplished through changes to the coverage for current retirees. Unless a program can be structured with a lower overall cost structure, this approach will result in shifting benefits costs from the employer to the retiree. Changes to the program design are usually accomplished most successfully over a period of years, rather than all at once. Many jurisdictions allow retirees to continue in the same benefit plans as when they were active employees. By designing a different program that addresses the specific needs of retirees, an overall lower cost might be achieved. For example, with the implementation of Medicare Advantage point-of-service plans and preferred provider organizations for Medicare-eligible retirees, the employer can provide a plan option with a lower overall cost while maintaining a full array of benefit features.

"GASB Statements No. 43 and No. 45 are already triggering close scrutiny of existing retiree health benefit programs."

- ***Use the Retiree Drug Subsidy Available under Medicare Part D to Subsidize Retiree Health Benefits*** Many public employers have applied for the retiree drug subsidy from Medicare available to employers to reimburse a portion of the amount spent on prescription drug coverage for eligible retirees. While the plan sponsor is not required to apply the Medicare subsidy received toward the cost of retiree benefits, by using the subsidy amounts to help fund the OPEB annual required contribution, the employer is ultimately moving more quickly toward full prefunding of liabilities. Under GASB rules, if the employer is directly receiving the Medicare Part D subsidy, it cannot project that subsidy as a future offset to OPEB obligations until received and applied to the OPEB funding. Contracting with a commercial PDP does allow projection of continued savings on a forward-looking basis. Plan sponsors, therefore, should analyze the most cost-effective way to participate in Medicare Part D. For example, contracting with a commercial Medicare Prescription Drug Plan (PDP) to provide the prescription drug benefits for Medicare retirees might result in pricing pass-through of larger amounts of subsidy than the plan sponsor could receive on its own.
- ***Redesign Coverage for Future Retirees*** Public employers may consider replacing the typical "defined benefit" retiree health benefit structure for future retirees by substituting a defined contribution approach in which future retirees are each provided an HRA. The employer's annual contribution to the account could vary depending on employees' years of service. Upon retirement, each retiree would use the money in his or her account to purchase commercially available insurance or to help fund purchase of the employer's health benefits priced without other subsidy. This represents a more dramatic change of approach from the traditional benefit structure.
- ***Restructure Subsidies for Current and/or Future Retirees*** Restructuring employee contribution levels for retiree health benefits may demonstrate to taxpayers that the jurisdiction is being proactive in identifying and reviewing likely sources for revenue. Although many jurisdictions provide the same subsidy to the retiree for health benefits as they provided to active employees, there is no requirement that this be the case.